VOICE REFERRAL FORM

Part I. General Information

Student's Name:_____ Gender:_____ DOB:_____

Address: _____ Parent's Name: _____
_____

School: _____ Grade:_____

Speech-Language Pathologist:_____Date: _____

Part II. Speech-language evaluation results (completed by a Speech-Language Pathologist)

Reason(s) for referral: _____
_____

Student's complaint (if any): _____
_____

Brief description voice (e.g., onset pattern, variations, impact on communication, student's level of awareness and motivation for possible therapy). Include relevant oral-peripheral examination and hearing screening/evaluation results.

Clinical Impressions: Rate each attribute (**1** = normal, **2** = Mild Impairment, **3** = Moderate Impairment, **4** = Severe Impairment, **5** = Profound Impairment, and **X** = Not Observed).

Quality (breathy, hoarse, harsh) _____
Pitch (too high/ too low) _____
Nasal resonance (hypo-/hypernasal/mixed)_____
Loudness (too soft/ too loud)_____
Pitch breaks _____
Glottal attack (hard/soft) _____

Muscle tension _____
Oral resonance _____
Phonation breaks_____
Breathing pattern_____
Abusive vocal behaviors____

Maximum phonation time: /a:/=_____seconds
s/z ratio (maximum /s:/= _____seconds/maximum /z:/= ____ seconds):

Other (describe in detail):_____
_____
_____

Signature of speech-language pathologist _____ Date _____

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Student's Name _____ Date _____

Part III. To be completed by the parent or caregiver

Instructions: Please circle "yes" or "no" and provide additional information as needed.

Does your child's voice sound like that of other family members? Yes No
Has he/she had frequent ear infections? Yes No
Does he/she have a sore throat frequently? Yes No
Does he/she have allergies? Yes No
Does he/she often breathe through the mouth? Yes No
Does he/she snore while sleeping? Yes No
Does your child seem unusually tense when speaking? Yes No
Have you noticed that your child has a persistent voice problem? Yes No
If yes Does your child's voice sound hoarse? Yes No
Does your child seem short of breath when speaking? Yes No
Does your child's voice sound as though it is coming through his/her nose rather than through the mouth? Yes No
Does your child's voice sound as though he/she has a stopped-up nose? Yes No
Does your child's voice sound worse in the morning? Yes No
in the evening? Yes No
Does your child seem to speak more loudly than necessary? Yes No
Has he/she had a serious injury to the neck? Yes No
to the head? Yes No
to the chest? Yes No
Has your child had any surgery to the lips, mouth, throat, or ears? Yes No
If yes, please describe and include dates _____
_____
Does your child have any problems swallowing? Yes No
Does he/she often have heartburn or acid indigestion? Yes No
Does your child use tobacco products? Yes No
Does your child consume caffeinated drinks? Yes No
Does he/she consume alcoholic beverages? Yes No
Is your child in choral groups, cheerleading, or other talkative activities? Yes No
Yes No
Is your child frequently exposed to dust, mold, or air-borne chemicals? Yes No
Does he/she have any other health problems? Yes No
Describe:_____
Is your child currently taking any medications? Yes No
Please list:_____
When did you first notice the problem and how has his/her voice changed since then?
_____
_____

Parent signature Date

_____ _____

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Student's Name _____ Date _____

Part IV: To be completed by a licensed physician.

What is the physical condition of the patient's larynx? _____
_____
_____

Are there any abnormal growths/edema on any part of the vocal mechanism? Yes No
If so, please specify type and location_____
_____

Are there vocal fold asymmetries during phonation? Yes No
If so, please describe_____
_____

Is there evidence of inadequate velopharyngeal function?Yes No
If so, please describe _____
_____

Is there obstruction(s) of the nasal passages? Yes No
If so, please explain_____
_____

Is there presence of any sinus infection or nasal allergy? Yes No

During phonation did the vocal folds exhibit normal amplitude? Yes No

Is there evidence of excessive muscular tension during phonation? Yes No

How were the vocal folds visualized during the examination? _____

What is your medical diagnosis?_____
_____

Are there any contraindications for voice therapy? Yes No

How may the Speech-Language Pathologist best contact you for consultation if needed?

Phone # _____ E-mail_____ (with parental consent)

_____ _____
Examining Physician's Signature Date

Please return this form to _____ at _____ (fax) or

_____ (address). Thank you.